



Race, Ethnicity, and Health: A New Data Policy

Jay S. Buechner, PhD, and Vania Brown-Small, MS, RN, CS

Virtually any analysis of the information we collect on Rhode Islanders' health status, health risks, access to health care, and utilization of health care services reveals large differences by racial and ethnic backgrounds. With few exceptions these health disparities favor non-Hispanic white residents over minority racial and ethnic groups.

The reduction and elimination of such disparities has been a national public health goal for decades; at the state level, the Rhode Island Department of Health adopted a policy for the collection of race and ethnicity data in health databases in 1988 and established an Office of Minority Health in 1992. After twelve years, we have revised the data policy. The implementation of the revisions will affect all who are involved in collecting and using health data in our state, including physicians.

BACKGROUND: MINORITY HEALTH DISPARITIES AND HEALTH DATA POLICIES

Healthy People 2000 had three fundamental goals; one was to reduce health disparities among all population subgroups and in particular among disadvantaged racial and ethnic populations.¹ *Healthy People 2010* set a goal of eliminating health disparities: all of the national health objectives for 2010 are identical across racial and ethnic groups, no matter how disparate their current baselines.²

Implicit in the adoption of such sweeping goals is the ability to document the health disparities and to monitor progress toward their elimination. Health data must have accurate and consistent reporting of the race and ethnicity of the persons under study. Nationally, Directive 15 of the Office of Management and Budget (1978)³ specified minimum categories to be used in collecting data

on race and Hispanic origin, as well as standardized methods of obtaining the data from the subjects themselves or from other reporters.

In 1988, the Rhode Island Department of Health, the Hospital Association, the Urban League, and Rhode Island Hospital jointly drafted a policy for the collection of data on race and ethnicity in health databases. This draft incorporated the federal directive and was the basis for the policy adopted by the Department of Health, covering its internal and collaborative data collection activities.⁴

ORIGINS OF THE REVISED POLICY

Two events precipitated the effort to revise the Department of Health's policy for collecting race and ethnicity data. In 1997 the federal government made fundamental policy changes in what race and ethnicity data are collected and how they are collected, to be implemented by January 1, 2003.⁵ (The 2000 US Census uses these new standards.) Because many state-level databases are components of national databases or are collected to national standards, the revised federal policy affected data collection at the state level.

Questions on Race and Hispanic Origin from Census 2000

NOTE: Please answer BOTH Questions 7 and 8.

7. Is Person 1 Spanish / Hispanic / Latino? Mark the "No" box if not Spanish/Hispanic/Latino.

- ☐ No, not Spanish / Hispanic / Latino
- ☐ Yes, Puerto Rican
- ☐ Yes, Mexican, Mexican Am., Chicano
- ☐ Yes, Cuban
- ☐ Yes, other Spanish / Hispanic / Latino —
Print group. _____

8. What is Person 1's race? Mark one or more races to indicate what this person considers himself/herself to be.

- ☐ White
- ☐ Black, African Am., or Negro
- ☐ American Indian or Alaska Native — Print name of enrolled or principal tribe. _____
- ☐ Asian Indian
- ☐ Japanese
- ☐ Native Hawaiian
- ☐ Chinese
- ☐ Korean
- ☐ Guamanian or Chamorro
- ☐ Filipino
- ☐ Vietnamese
- ☐ Samoan
- ☐ Other Asian — Print race. _____
- ☐ Other Pacific Islander —
Print race. _____
- ☐ Some other race —
Print race. _____

In September 1998, the Department's Minority Health Advisory Committee and senior staff engaged in a retreat to develop a statewide strategic plan for minority health. As one objective, the Department would revise and implement its data policy on race and ethnicity, with the purpose of improving the accuracy and consistency of data on the health of the state's minorities.

THE PROCESS OF REVISION

The development of the revised policy was led by the Office of Minority Health in partnership with the Office of Health Statistics. In addition to the federal policy, data collection policies of federal health agencies, health agencies in other states, and other state agencies in Rhode Island were sought. A review was conducted of the few existing policies. With the assistance of database managers in the Department of Health and the Data Subcommittee of the Minority Health Advisory Committee, a draft policy was submitted to the Minority Health Advisory Committee and to the Department's Executive Committee for review. After public comment and review, the Department of Health adopted the new "Policy for Maintaining, Collecting, and Presenting Data on Race and Ethnicity" in July 2000.

COMPONENTS OF THE REVISED POLICY

The Department's revised policy incorporates the new federal policy as a minimum standard. A summary of the policy's key components is as follows:

- The policy applies to all HEALTH databases and data collection activities, with specified exceptions.
- Self-identification is the standard method for collection of data. Where self-identification is impossible or otherwise not feasible, identification by a family member is an acceptable alternative. Identification by observation is the least satisfactory method.
- Race and Hispanic/Latino origin are to be asked as separate questions, with the Hispanic/Latino origin question asked first.
- The five minimum categories to be used in collecting data on race are American Indian or Alaska Native; Asian; Native Hawaiian or Other Pacific Islander; Black or African American; and White. If more detailed race categories are used, they must be collapsible into the five minimum categories. The policy provides optional expanded categories for race and Hispanic/Latino origin appropriate for Rhode Island's population.
- Respondents must be given the option of selecting more than one race category. This should not be accomplished by the use of a single multiracial category.
- Where possible, data items that help explain observed health disparities among racial and

ethnic groups, such as socioeconomic variables, should be collected and analyzed in conjunction with race and ethnicity data.

The revised policy is to be implemented in all databases by January 1, 2003. The text box shows the 2000 Census Bureau's race and Hispanic/Latino origin questions, which illustrate key components of the new policy

IMPLEMENTATION OF THE REVISED POLICY

Within HEALTH, all databases covered by the revised policy will be identified and prioritized. Then each database will undergo a three-step process:

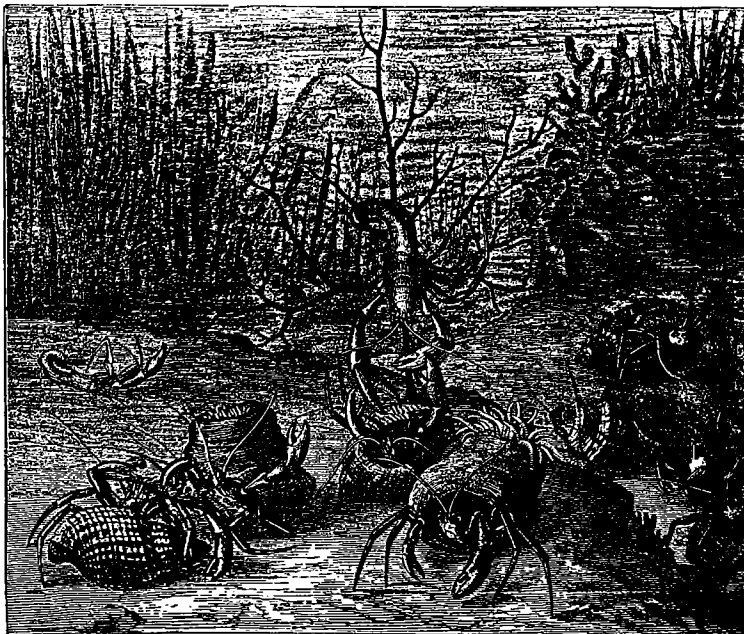
1) Inventory current collection practices for race and ethnicity data, including any applicable regulations, data collection forms, instructions and training manuals, data entry programs, etc.

2) Identify and make needed changes in regulations, forms, instructions, manuals, data entry programs, reports, and documentation. Train data collectors in new procedures.

3) Monitor and evaluate the new procedures during the initial data collection period and regularly thereafter.

KEY ISSUES IN USING DATA COLLECTED UNDER THE REVISED POLICY

The race and ethnicity data after these policies go into effect will be different than under the old standards. The "multiple race" response-option in particular raises some difficult decisions. One issue will be how to present data on persons who indicate multiple races. Some options being considered include (1) establishing separate categories for the most common combinations of two (or more) races and (2) including persons with multiple races in all the race categories they indicate, so that race categories will not be



mutually exclusive. A second issue is how to analyze and present trend data over the break in data collection methods, since the multiple-race option will limit comparability with earlier data.

IMPACT ON PHYSICIANS

For many of the databases used for public health surveillance and statistics, a central source of information on race and Hispanic/Latino origin is the physician. Of 30 key HEALTH databases, physicians are either a primary source or the sole source of the collected information in 20 (67%).⁶ In five of the databases, physicians report data directly to the Department (e.g., reportable infectious diseases); in another eight, physicians contribute to the medical records from which reported data are drawn (e.g., hospital discharge data); in the remaining seven, physicians serve as data sources in both ways (e.g., birth records).

As the Department implements the revised data collection standards, physicians will be increasingly involved in their roles as data sources. There will be a renewed emphasis on the collection of complete and accurate data on race and ethnicity of patients, and there will be guidance for physicians in obtaining this information in the new format. During the period of change, physicians are encouraged to remember the rationale behind the collection of these data - improving the health of the state's disadvantaged populations.

Jay Buechner, PhD, is Chief, Office of Health Statistics, Rhode Island Department of Health, and Clinical Assistant Professor of Community Health, Brown Medical School.

Vania Brown-Small, MS, RN, CS, is Minority Health Coordinator, Office of Minority Health, Rhode Island Department of Health.

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2. US Department of Health and Human Services. *Healthy People 2010: 2nd ed. Understanding and Improving Health and Objectives for Improving Health*. (2 vols.) Washington, DC: US Government Printing Office. November 2000.
3. US Office of Management and Budget. Statistical Policy Directive No. 15: Race and Ethnic Standards for Federal Statistics and Administrative Reporting. Statistical Policy Handbook. US Department of Commerce, Office of Federal Statistical Policy and Standards. 1978.
4. See, for example, Rhode Island Department of Health. *Healthy Rhode Islanders 2000 Progress Review*. Providence, RI. March 2001.
5. US Office of Management and Budget. Revisions to the Standards for the Classification of Federal Data on Race and Ethnicity. Washington, DC: Executive Office of the President, Office of Management and Budget, Office of Information and Regulatory Affairs. October 1997.
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Vital Statistics

Rhode Island Department of Health

Patricia A. Nolan, MD, MPH, Director of Health

Edited by Roberta A. Chevoya

Rhode Island Monthly Vital Statistics Report

Provisional Occurrence Data
from the
Division of Vital Records

Underlying Cause of Death	Reporting Period			
	July 2000	12 Months Ending with July 2000		
	Number (a)	Number (a)	Rates (b)	YPLL (c)
Diseases of the Heart	235	3,088	312.4	3,814.5
Malignant Neoplasms	214	2,454	248.3	6,555.0
Cerebrovascular Diseases	35	507	51.3	854.5
Injuries (Accident/Suicide/Homicide)	33	364	36.8	7,030.5
COPD	28	456	46.1	287.5

Vital Events	Reporting Period		
	January 2001	12 Months Ending with January 2001	
	Number	Number	Rates
Live Births	846	12,965	13.1*
Deaths	988	9,995	10.1*
Infant Deaths	(12)	(92)	7.1#
Neonatal deaths	(9)	(78)	6.0#
Marriages	318	8,054	8.1*
Divorces	158	2,986	3.0*
Induced Terminations	495	5,521	425.8#
Spontaneous Fetal Deaths	19	894	69.0#
Under 20 weeks gestation	(17)	(827)	63.8#
20+ weeks gestation	(2)	(67)	5.2#

(a) Cause of death statistics were derived from the underlying cause of death reported by physicians on death certificates.

(b) Rates per 100,000 estimated population of 988,480

(c) Years of Potential Life Lost (YPLL)

Note: Totals represent vital events which occurred in Rhode Island for the reporting periods listed above. Monthly provisional totals should be analyzed with caution because the numbers may be small and subject to seasonal variation.

* Rates per 1,000 estimated population

Rates per 1,000 live births